Benjamin Lee, MD
2012 S. Tollgate Road, Suite 102
Bel Air, Maryland 21015
Phone: (443) 490-4000
Fax: (443) 484-2831

Patient Financial Liability Form

Insurance will be accepted under the following conditions:
The information that you provide is accurate and current. Any changes in coverage or policy are your responsibility. Should you have a change in coverage or policy, you must notify us prior to your next appointment so that we can make sure you receive the proper insurance coverage. All co-payments are due at the time of service. You are responsible to pay your deductibles and coinsurance within 30 days from determination by your insurance carrier or at your next visit, which ever comes first. Should the insurance company deem any service as "patient liability", you will be held responsible for that service. All outstanding patient balances must be paid before another session with Dr. Lee or Chesapeake Pain Center will occur. For your convenience we accept cash, VISA and Mastercard.

Patient's are fully responsible for obtaining a referral from their primary care physician should one be required and any service denied for lack of a referral will be your responsibility. The Office of Dr. Benjamin Lee makes every effort to obtain accurate information from your insurance carrier however; a verification of benefits is never a guarantee of claim payment. The insurance carrier makes the final determination of payment and who is to be held liable for the claim balance.

We bill the insurance companies that we participate with; however, if we are not paid in a timely fashion, you will be responsible for the bill and expected to pay in full. Please note that although we participate with certain insurance plans, some charges may not be covered under those plans, (co-payments, medical equipment & supplies, etc...) except as provided by such contract or state law, we will hold you responsible for all charges not paid by your insurance carrier.

I hereby authorize the office of Dr. Benjamin Lee to furnish information to my insurance carriers concerning my illness/injury and treatment. I hereby assign Dr. Benjamin Lee any and all payments for medical services rendered to myself and/or dependents. In the event that my insurance company sends payment/check for services rendered to me and not to Dr. Benjamin Lee, I _____ agree to submit payment or sign check over to the office of Dr. Benjamin Lee within 30 days. I understand that I am responsible for any amount not covered by my insurance. I also understand that if my account is turned over to a collection agency and/or legal counsel, I will be responsible for any collection and/or legal fees and compound annual interest rate at 17% for balances due past 90 days.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

Revised/Approved 5/2016